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Commonwealth of Virginia

Virginia Board for People with Disabilities

| **Mary McAdam** | Washington Building, Capitol Square | 804-786-0016 (TTY/Voice) |
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| Chair | 1100 Bank Street, 7th Floor | 1-800-846-4464 (TTY/ Voice) |
| **Rachel Loughlin** | Richmond, Virginia 23219 | 804-786-1118 (Fax) |
| Vice Chair |  | info@vbpd.virginia.gov |
| **Jamie Snead** |  | www.vaboard.org |
| Secretary |  |  |
| **Heidi L. Lawyer** |  |  |
| Executive Director |  |  |

April 1, 2019

TO: Emily McClellan, Regulatory Supervisor

[Emily.McCellan@dmas.virginia.gov](mailto:Emily.McCellan@dmas.virginia.gov)  
Department of Medical Assistance Services

FROM: Heidi L. Lawyer Signature

RE: Comment on 12VAC30-120, Waiver Services/12VAC30-122, Community Waiver Services for Individuals with Developmental Disabilities (adding 12 VAC 30-122-10 through 12VAC30-122-570).

I am writing to provide comments on behalf of the Virginia Board for People with Disabilities (the Board) regarding Virginia’s Developmental Disabilities waiver service regulations. The Board appreciates the opportunity to provide input on the proposed regulations, which replace emergency regulations that expired in 2018.

The Board continues to support the redesign of Virginia’s Medicaid Waiver System.

The Board offers the following recommendations to improve the DD Waiver regulations, organized by regulatory citation.

**12 VAC 30-50-440. Support coordination/case management services for individuals with intellectual disability.**

1. **Subsection D: The Board recommends adding a new item at the end of the numbered list that states, “9. Be available to the individual during standard business hours by telephone, and assist the individual upon request.”** This language would explicitly state that one of the support coordinator’s responsibilities is to be available to the individual, and is consistent with language used with respect to service facilitators in 12 VAC 30-122-500 B.
2. **Subdivision E 3a(1): The Board recommends expanding this item to state, “The definition and causes of intellectual disability (ID), barriers faced by people with intellectual disabilities in community living, and best practices in supporting individuals who have intellectual disability;”** Understanding the barriers faced by persons with ID, will help the support coordinator’s ability to meet other requirements such as having knowledge of best practices in supporting individuals who have ID, having knowledge of treatment modalities and intervention techniques, having the skills to identify an individual’s needs, and having the ability to demonstrate a positive regard for individuals and their families.
3. **Subdivision E 3a: The Board recommends adding a new item at the end of this subdivision that states, “(10) Cultural competency.”** While support coordinators are required in Subdivision E 3c(1) to have the ability to “demonstrate a positive regard for individuals and their families,” that requirement does not necessarily encompass all aspects of cultural competency.
4. **Subdivision E 3b: The Board recommends adding a new item at the end of this subdivision that states, “(11) Evaluating the effectiveness of support plans and the individual’s satisfaction with their services and supports, and updating the support plans as necessary.”** While a key role of the support coordinator is to monitor and update support plans as needed, none of the required knowledge, skills, or abilities specifically speak to this role. Part of monitoring should include assessing an individual’s satisfaction level. Because some individuals may not be comfortable expressing dissatisfaction or may have communication or other challenges that create a barrier to participating in a traditional mode of satisfaction inquiry.

**12VAC30-50-490. Support coordination case management for individuals with developmental disabilities, including autism.**

1. **The Board recommends eliminating the term autism in the section header.** Autism/Autism Spectrum Disorders (ASD) are included in the term developmental disability.
2. **Subsection A: The Board recommends eliminating the limitation of case management to individuals who are six years of age and older and who are on the waiting list or receiving services.** Since we have moved to a DD Waiver system that does not differentiate based on diagnosis, there should not be an age restriction to the receipt of case management services. This is a remnant from the old IFDDS waiver where children under six were all served through the ID waiver. If individuals under the age of six are not in the target group, then it is unclear how they would gain a slot on the DD Waiver wait list or receive a DD waiver.
3. **Subdivision A 2: The Board recommends requiring annual contact by telephone between the support coordinator and persons on the Waiver waiting list who are not receiving support coordination because they are not receiving a special service**. In addition to verifying waiting list placement, the contact could identify special services that the person may need at that time. 12VAC30-122-79 does requires documentation of annual contact with individuals on waiting list to provide institutional vs. waiver placement choice consistent with 12VAC30-50-440 and 490 (regulatory provisions governing case management).
4. **The Board recommends consistency between Subsection B, (“Comparability of Services”) and Subsection D (“Definition of Services”):** Subsection C states, with respect to support coordination/case management, that “CSBs or BHAs **shall** contract with private support coordination/case managers for this service.” However Subdivision D 1(“Definition of Services”) states that “CSBs or BHAs **may** contract with other entities to provide support coordination /case management services.” There should be consistency in these two sections, either shall or may, based on the legal requirement.
5. **Subdivision D: The Board recommends adding a new item at the end of the numbered list that states, “9. Be available to the individual during standard business hours by telephone, and assist the individual upon request.”** This language would explicitly state that one of the support coordinator’s responsibilities is to be available to the individual, and is consistent with language used with respect to service facilitators in 12 VAC 30-122-500 B.
6. **Subsection E 6a**: **The Board recommends expanding this item to state, “The definition and causes of developmental disability (DD), barriers faced by people with DD in community living, and best practices in supporting individuals who have developmental disabilities;”** Understanding the barriers individuals with DD face will help the support coordinator to meet other requirements such as having knowledge of best practices in supporting individuals who have developmental disabilities, having knowledge of treatment modalities and intervention techniques, having the skills to identify an individual’s needs, and having the ability to demonstrate a positive regard for individuals and their families.
7. **Subdivision E 6a: The Board recommends adding a new item at the end of this subdivision that states, “(10) Cultural competency.”** While support coordinators are required in Subdivision E 6c(1) to have the ability to “demonstrate a positive regard for individuals and their families,” that requirement does not necessarily encompass all aspects of cultural competency.
8. **Subdivision E 6b: The Board recommends adding a new item at the end of this subdivision that states, “(10) Evaluating the effectiveness of support plans and the individual’s satisfaction with their services and supports, and updating the support plans as necessary.”** While a key role of the support coordinator is to monitor and update support plans as needed, none of the required knowledge, skills, or abilities specifically speak to this role. Part of monitoring should include assessing an individual’s satisfaction level. Because some individuals may not be comfortable expressing dissatisfaction or may have communication or other challenges that create a barrier to participating in a traditional mode of satisfaction inquiry.
9. **Subdivision E 8: The Board recommends increasing the frequency of documented supervision for support coordinators who are in their first year of employment.** This subdivision requires that support coordinators obtain at least one hour of documented supervision at least every three months. However, support coordinators who are new to the role should undergo more frequent supervision. The Board recommends at least one hour of documented supervision every month for the first year for these employees.

**12VAC30-122-20. Definitions**

1. **General. The Board recommends adding definitions for benefits planning, community guide, non-medical transportation, workplace assistance, and peer support.** If it is too late in the regulatory process to make a substantive change, DMAS should begin the emergency regulatory process for definitions, service descriptions, and other relevant information needed to implement these already approved services.
2. **Assistive Technology. The Board recommends expanding the definition as follows: “‘**AT means specialized medical equipment and supplies, including those devices, controls, or appliances specified in the individual support plan but not available under the State Plan for Medical Assistance that (1) enable individuals to increase their abilities to perform ADLs, or to (2) enable individuals to perceive, control, or communicate with the environment ~~in which they live~~, and (3) enable individuals to actively participate in other waiver services which are part of their plan, or (4) that are necessary to the proper functioning of the specialized equipment.” The current definition does not account for the new and future uses of technology which are more expansive than those specified in this definition.
3. **Community Engagement. The Board recommends deleting the reference to staff in the definition.** It is enough to denote that the group of individuals participating in the service can be no larger than three.
4. **Independent Living. The Board recommends adding a definition of Independent Living.** The phrase “independent living” is used in multiple places throughout the proposed regulations. Proposed12VAC30-122-90 defines the eligibility criteria for the Priority One waiting list to include young adults who are no longer eligible for IDEA services and who are transitioning to “independent living.” The regulations describe the individuals whom the Building Independence Waiver is designed to support as “individuals who reside in an integrated, independent living arrangement....” (proposed 12VAC30-122-240). Additionally, the Independent living support service described in proposed 12VAC30-122-420 is available to adults 18 years of age and older to provide the skill building and supports “necessary to secure and reside in an independent living situation.” Nowhere in the regulations, however, is the phrase “independent living” as used in these sections defined.
5. **Positive behavior supports. The Board recommends a more user friendly, clear definition of positive behavior supports.** One definition that could be considered is from the Association of Positive Behavior Supports: “Positive Behavior Support (PBS) is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment.” Note that the Board prefers the use of the term “challenging” to “problem” behavior, should this or another definition be adopted.
6. **Service Authorization**. **The Board recommends deleting the word “medically.”** While DD waiver services are all Medicaid-funded services, not all services authorized or funded under the waiver are medical in nature, e.g., ordered by a physician (e.g., employment, community engagement, etc.). Services are developed in accordance with the person-centered plan.
7. **Supported Living Residential. The Board recommends deleting “an apartment setting,” and changing to a service “taking place in the individual’s ‘own home.’”** Not all supported living residential settings are apartments.

**12VAC30-122-40. Waiver services: when not authorized.**

1. **Subsection B: The Board recommends clarifying that transition services can be provided to individuals who are inpatients at the listed facilities when they are preparing for discharge.** The subsection states that waiver services shall not be furnished to individuals who are inpatients of a hospital, nursing facilities, ICF/IID, or inpatient rehabilitation facility. It goes on to state that waiver services shall not be provided until the individual has exited the institution and has been enrolled in the waiver. However, some of the costs covered by transition services would have to be incurred prior to the individual exiting the institution, in order for the individual to have an alternative place to live. Such expenses include security deposits, set-up fees, or deposits for utilities, etc.

**12VAC30-122-60 Financial eligibility**

1. **Subdivision B 3a(1): The Board recommends striking “at least eight” as follows:** “For an individual employed ~~at least eight but~~ less than 20 hours per week, earned income shall be disregarded up to a maximum of both earned and unearned income up to 200%.” Some individuals for medical or other reasons may work less than eight hours a week and without the disregard, there is no incentive for them to work because all of their income would go to cover their patient pay.
2. **Subdivision B 3b(1): The Board recommends the same changes as noted above for B 3a(1).**
3. **Subdivision B 3: The Board recommends that Patient Pay be considered an Income Related Work Expense (IRWE).** IRWEs are already considered when countable earned income is considered. Without waiver services, an individual would not be earning at the level they are earning. But, earning at a higher level is forcing them to incur a Patient Pay. This is a disincentive to earn wages at a higher level.

**12VAC30-122-80 Waiver approval process**

1. **Subdivision C 3:** **The Board recommends adding “and other service plans, as applicable” at the end of this subdivision.** This subdivision relates to signature on the individual service plan by the individual, family member and support coordinator. In addition to the ISP, there may be other provider service plans that are agreed to and should be signed (e.g., an employment plan).
2. **Subdivision C 4:** **The Board recommends changing 30 days to 90 days and to ensure that references to days (days vs. calendar days) are consistent.** There are a variety of reasons that can create a delay of service initiation beyond 30 days. The individual should not be penalized by having to undergo another financial eligibility determination because the provider does not initiate services in a timely manner. It is unlikely that there would be a significant change in financial circumstances within a 30-day period. Furthermore, since the individual/family have up to 30 days to contact the provider, should this contact be made on day 29, services clearly could not be initiated by day 30.
3. **Subdivision C 6c:** **The Board recommends that the term** “**suspend” should be changed to “pend,” which is the terminology currently utilized when seeking more information.**

**12VAC30-122-90 Waiting list**

1. **Subdivision C 1a: The Board recommends striking “there are no other unpaid caregivers” and changing it to “or there are no unpaid caregivers” to read as follows: “**An immediate jeopardy exists to the health and safety of the individual due to the unpaid primary caregiver having a chronic, long term physical or psychiatric condition that currently significantly limits the ability of the primary caregiver to care for the individual; or there are no ~~other~~ unpaid caregivers available to provide services.”  
   The way this provision is currently written, the portion of the sentence is inter-related to the first sentence, which could be interpreted as there are no unpaid caregivers in the event of the primary caregiver having a chronic condition. An individual should be on Priority 1 if there are no unpaid caregivers available, without qualification.
2. **Subdivision C 1b: The Board recommends adding a new criterion as follows: “or (3) the age of the primary caregiver is 70 or greater.”** The Board supported the removal of age 55 as a criteria for Priority 1. However, there are growing numbers of aging parents, well beyond age 55, who need to be able to plan for their child’s future. The Board agrees with the recommendation from the DD Waiver Advisory Council participants that 70 is a reasonable age to add as a criterion.
3. **Subdivision C 1b(1): The Board recommends striking “by the primary caregiver or unpaid provider”** as follows**: “**The individual’s behavior, presenting a risk to himself or others, cannot be effectively managed ~~by the primary caregiver or unpaid provider~~ even with support coordinator arranged generic or specialized supports….” It is possible that an individual may not have a primary caregiver. They may be living independently and experience a crisis. The focus should be on the inability to manage the behavior even with additional supports.
4. **Subdivision C 1b(2): The Board recommends striking “by the primary caregiver.”** The reason mirrors Comment #29 above.
5. **Subdivision C 1d: The Board recommends the following addition: “**The individual is a young adult who is no longer eligible for IDEA services and is transitioning or has expressed a desire to transition to independent living. After individuals attain 27 years of age, this criterion shall no longer apply.” As written, the regulation implies that the transition is underway; however, the individual may need the waiver slot in order to begin the transition.
6. **Subdivision E 3: The Board recommends striking the last sentence of this subdivision which states, “A regional WSAC session will then be held for the remainder of available slots, reviewing those individuals meeting criteria for Priority Two and then Priority Three.”** The purpose of having a priority system is that individuals in Priority 1 be served prior to anyone in other priorities who, by the nature of being placed in a lower priority, have indicated they don’t need services for at least a year (or in the case of Priority 3, more than five years). We recognize this may be a controversial recommendation; however, if Building Independence waiver slots are going to individuals on Priority 2 and 3 because individuals on Priority 1 are unable or unwilling to benefit from the BI waiver, this implies that these slots are not needed and that slot requests should be geared to the FIS and CL waivers which are more appropriate to Priority 1. In other sections, the Board is recommending that certain key services be added to the BI waiver. This may make that waiver more likely to provide services from which individuals on Priority 1 can benefit.

**12VAC30-122-120 Provider Requirements**

1. **Subdivision A 4: The Board recommends changing 30 days to 90 days.** There may be unforeseen barriers, including bureaucratic hurdles, which prevent the initiation of services within 30 days.
2. **Subdivision A 5: The Board recommends removing the term “medically necessary” since the key to the plan is to provide person-centered services.** The provision would begin as follows: **“**Provide ~~medically~~ necessary services and supplies for individuals in accordance with the ISP….”
3. **Subsection D: The Board recommends changing may to shall with respect to the referral to program integrity for providers who demonstrate a history of non-compliance**. The sentence would read, “Failure to complete the mandatory training or identified technical assistance ~~may~~ shall result in referral to DMAS Program Integrity or termination of the provider Medicaid participation agreement.”
4. **Subdivision A 10d: The Board recommends striking the word “medical” to read as follows: “**Providers shall prepare and maintain unique person centered progress note written documentation in each individual’s ~~medical~~ record regarding their response to services and rendered supports.” Not all records are medical.
5. **Subdivision A 10d: the Board recommends adding, if applicable within the parenthetical: “**Providers shall maintain an attendance log or similar document that indicates the date services were rendered, type of services rendered, and number of hours or units provided (including specific timeframe, if applicable)….” Not all services are delivered in hourly units and the day the service is provided is already required.
6. **Subdivision A 13: The Board recommends changing the code citation from 37.2-600 to 37.2-607.**
7. **Subdivision A 14: The Board recommends removing the DBHDS Office of Licensure from the list of entities to whom abuse or neglect should be reported.** These are required to be reported to the DBHDS Office of Human Rights.
8. **Subsection D: The Board recommends that the regulations discuss what additional remedial actions for providers, beyond mandatory training or technical assistance, can be taken and the circumstances in which each of these actions will be taken.** The regulations state that providers with a history of noncompliance will be required to undergo mandatory training and technical assistance. However, it is unclear what steps would be taken if a provider continues to be out of compliance following participation in the mandatory training or technical assistance. Would additional training or technical assistance be required? Would other remedial actions such as fines or provider enrollment freezes be implemented? At what point will providers’ Medicaid participation agreements be terminated?

**12VAC30-122-150. Requirements for consumer-directed model of service delivery**

1. **Subdivision A 2a: The Board recommends modifying the second sentence of this subdivision to state, “If an individual is unable or unwilling to direct his own care or is younger than 18 years of age, he may designate another person older than 18 years of age to serve as the employer of record (EOR) on his behalf.”** Individuals who are capable of, but unwilling to, direct their own care should also be allowed to designate an EOR if desired.

**12VAC30-122-160. Voluntary or involuntary disenrollment of consumer-directed services.**

1. **Subdivision 3: The Board recommends adding a new item to the lettered list that states that the service facilitator or care coordinator shall “Take intermediate steps to address emerging issues – such as alerting the individual of the challenges, facilitating the appointment of an employer of record, providing additional training and assistance, and collaborating with the member or representative, service facilitator, and the Department – and document the intermediate steps taken**.” At a minimum, additional safeguards should be implemented prior to involuntary disenrollment, as suggested in the Joint Legislative Audit and Review Commission’s December 2016 report, Managing Spending in Virginia’s Medicaid Program (see pages 74-5). Intermediate steps should be taken as soon as emerging issues become apparent.

**12VAC30-122-180 Orientation testing, professional competency requirements, advanced competency requirements**

1. **Subdivision A 1e: The Board recommends adding a new item at the end of this subdivision that states, “(e) Cultural competence.”** It is important that direct support professionals understand how to respect cultural differences of the individuals they serve.
2. **Subsections C and D:** **The Board recommends that all core competency training and professional assurances be completed prior to working with an individual, including specialized services needed by the individual. Advanced competencies not directly related to working with the individual can have a longer timeframe for completion as the list is extremely lengthy.** The Board understands the need to have an observation period for completing the competency checklist. However,the Board is concerned that new direct support professionals (DSPs) and DSP supervisors have 180 days from date of hire to complete competency training, in the case of licensed providers, and 180 days to complete professional assurances in the case of non-licensed providers. Requiring completion of competency training and professional assurances prior to working with the individual would be feasible and consistent with requirements for service facilitators in 12 VAC 30-122-500 D 2e.
3. **Subdivision D 1: The Board recommends changing “provider record” to “personnel file or record” with respect to the documentation of assurances required to be maintained regarding DSP training.** Records relate to individual personnel.

**12VAC30-122-190 Individual support plan; plan for supports; reevaluation of service need**

1. **Subdivision A 8: The Board recommends adding the word, “by the support coordinator” at the end of the sentence.** This clarifies that support coordinator is responsible for providing a copy of the ISP to individual-family

**12VAC30-122-200 Supports Intensity Scale requirements; Virginia Supplemental Questions; levels of supports; support packages**

1. **Subdivision A 1: The Board recommends deleting “to 72” and adding “or older” after “years of age” as follows:** “DBHDS shall use the SIS Adult for individuals who are 16 ~~to 72~~ years of age or older.” If the SIS is only validated to age 72, then language should be added to automatically assign individuals age 72 or older to Level 5, Tier 4. Level 5 is the highest level denoting significant need in general but not specifying it to medical or behavioral needs. Tier 4 is mid-range denoting significant need, which is appropriate for an aging population.
2. **Subdivision A 2: The Board recommends revising the regulation to reflect a four-year time frame for re-administration of the SIS for individuals 16 years or older, rather than three years.** The Renewal Application for the Community Living Waiver changes SIS administration for this population to every four years or sooner if needed. The Board supports this change.
3. **Subdivision A 4: The Board recommends removing the scoring protocol.** This should be included in a Medicaid Memo or the Manual, not in regulations, in the event the scoring rubric changes.
4. **Subsection D: The Board recommends striking this subsection, which is a reserved section intended to explain the establishment of supports packages as a profile of the mix and extent of services anticipated to be needed by individuals with similar levels, needs, and abilities**. In light of 2019 General Assembly budget language which prohibits the implementation of supports package unless specifically authorized by the General Assembly, this section is not necessary.
5. **Subsection D: The Board recommends replacing the current reserved subsection D and adding a new subsection D which requires (i) that the results of the SIS be provided within 10 days of scoring to the individual and family in an understandable format and (ii) that the service coordinator be required to explain the results and implications of the SIS score and avenues of appeal.** Currently families do not receive their SIS score, receive it on a delayed basis, and/or do not understand the implications of the scores since they are not explained.
6. **Subsection E: The Board recommends adding a new subsection requiring an independent review, upon request of the individual or family, of the SIS administration process and results when an individual’s SIS Score changes but their health or other life circumstances have not.** Many families have indicated that their loved ones’ SIS scores has changed, in most cases to a lower score, without a change in circumstances. Since the SIS Score is not appealable, only the process, a   
   re-administration upon request would best serve individuals and families.

**12VAC30-122-210 Payment for Covered Services**

1. **Subdivision A 4e: The Board recommends modifying the wording to state, “The DMAS designee shall review each individual’s needs on at least**….” Individuals themselves are not being reviewed, but rather their needs.
2. **Subdivision C 1: The Board recommends a review of the $5,000 annual limit on assistive technology and, based on the results of the review, consider increasing the annual maximum to a level deemed appropriate to the cost and utility of today’s technology.** The current limit is years old and has not kept up with changes in technology and/or the emphasis on expanding the use of technology to replace more cost intensive staffing services. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new assistive technology without raising the overall multi-year dollar limits. The limit is also included in **12VAC30-122-270** **Assistive technology service.**
3. **Subdivision C 1: The Board recommends a review of the $5,000 annual limit increasing the annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications.** This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.
4. **Subdivision C 3: The Board recommends a review of the cost of electronic home-based supports to determine whether the individual maximum of $5,000 per calendar year is sufficient for up-to-date technology as well as any associated monthly monitoring fees.** The purpose of these supports is to enable individuals who so desire to live more independently with less staff intrusion into their lives. The benefit should be consistent with the average cost of this type of support. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new electronic home-based supports technology without raising the overall multi-year dollar limits.

**12VAC30-122-240 – Services covered: Building Independence Waiver**

1. **Subsection B: The Board recommends adding personal assistance services (agency and consumer-directed), companion services (agency and consumer-directed), individual and family caregiving, and workplace assistance to the BI waiver.** These are all services that can benefit individuals on the BI waiver without significant additional cost. The BI waiver is meant for individuals with less significant needs; this means that there is likely a larger proportion of individuals with physical developmental disabilities on this waiver. Personal Assistance services is a key service to maintaining independence. Companion services can assist these individuals with skill building in the community and workplace assistance can help people on this waiver maintain employment, facilitating even greater independence. Individual and family caregiver training should be in all waivers. With the addition of these services, there may be more interest in utilizing this lower cost waiver by persons on the Priority 1 waiting list, helping to resolve the issue of the Commonwealth awarding BI slots to persons on the Priority 2 and 3 waiting lists.

**12VAC30-122-250 – Services covered: Community Living Waiver**

1. **Subsection B: The Board recommends adding individual and family caregiver training to this waiver.** There is no reason why this service should only be in the FIS waiver as it is applicable to all individuals and their families.

**12VAC30-122-260 – Services covered: Family and Individual Supports Waiver**

1. **Subsection B: The Board recommends adding the Independent Living Services to the FIS waiver.** This service can assist those living on their own or wishing to live on their own to be more independent.

**12VAC30-122-270. Assistive Technology**

1. **Subdivision A: The Board recommends striking “with the environment in which they live” from item (ii), adding a new (iii) “actively participate in other waiver services which are part of their plan, and renumbering the current item (iii) to item (iv).** The new section would read as follows: **“**AT services shall entail the provision of specialized medical equipment and supplies including…that (i) enable individuals to increase their abilities to perform activities of daily living; (ii) enable individuals to perceive, control, or communicate ~~with the environment in which they live~~; (iii) actively participate in other waiver services that are part of their plan; or (iv) are necessary for life support…”Waiver services and supports are designed to promote inclusion in all aspects of community life. They are not and should not be limited to the environment in which the individual lives. AT should be available to support any service in a person’s ISP.

**12VAC30-122-280 Benefits planning service**

1. **This section is reserved; however, benefits planning is now an available service and the Board recommends addressing the service in the regulations.**

**12VAC30-122-310 Community Coaching**

1. **Subdivision C 3: The Board recommends striking the sentence, “This service shall not be provided within a group setting.”** This sentence is not necessary and has the potential to prevent the individual from learning how to interact and communicate with others in a community engagement setting, the entire purpose of the service. Requiring the service to be one-on-one is sufficient.

**12VAC30-122-330 Community guide**

1. **This section is reserved; however community guide is now an available service and the Board recommends addressing it in the regulations.**

**12VAC30-122-340 Companion services**

1. **Subdivision C 1: The Board recommends eliminating the limit of the service to eight hours per 24 hour per day.** The waivers already allow a combination of various services to flexibly accommodate an individual’s needs. Companion services are inexpensive and there may be times when an individual requires more than eight hours of this service in a given day. The authorization should be an annual amount of hours that can be used as the individual needs them. Eight hours per day is an arbitrary cap. Other services don’t have a daily limit.

**12VAC30-122-360 Electronic home-based support services**

1. **Subdivision B 1:** **The Board recommends removing the word “physically**.” The section notes that the individual must be “physically” capable of using the equipment provided via EHBS service. Some EHBS services may be voice activated and not require physical manipulation. Although voice activation could be considered “physical,” this provision could be misunderstood.
2. **Subdivision C 1: As recommended in previous sections of these comments, the Board recommends that DMAS examine whether $5,000 is an adequate annual limit, particularly with respect to home-based monitoring services which can mitigate the need for in-person supports.**

**12VAC30-122-370 Environmental modifications services**

1. **Subdivision C 2: As noted previously, the Board recommends a review of the $5,000 annual limit increasing the annual limit for environmental modifications from the current maximum annual cap of $5,000 to a level deemed appropriate to the cost of such modifications.** This limit is years old and it is increasingly difficult for families and individuals to secure modifications that will allow them to remain in their homes over their lifespan for this small amount of funding. If raising the overall limit is not feasible at this time, then the Board recommends adopting a multi-year limit, such as $10,000 over the course of two years. This would allow greater flexibility for individuals to accommodate upfront costs of purchasing new environmental modifications without raising the overall multi-year dollar limits.
2. **Subdivision C 6: The Board recommends that an exception process be put into place for the uncommon circumstance in which the expansion of square footage to the home (which is prohibited) is an incidental result of a modification that will enable the individual to remain in their home, e.g., a larger, accessible bathroom**. Limits could be put into place for how much additional square footage would be allowable in an exceptions process.

**12VAC30-122-400-Group and Individual Supported Employment**

1. **Subdivision B 1: The Board recommends restricting this provision for clarity as follows:** “Only activities that specifically pertain to the individual shall be allowable activities under this service, and DMAS shall cover this service only after determining that the individual enrolled in the waiver cannot receive this service from DARS or for individuals under 22 years of age, and still enrolled in school, from the local school system.
2. **Subdivision C 3: The Board recommends striking “and individual” as follows: “**Group ~~and individual~~ supported employment service shall take place in nonresidential settings separate from the individual’s home.”Individual supported employment must be able to be provided in an individual’s home for purposes of self-employment or other individuals that work from home for other employers (telecommuting, etc.).
3. **Subdivision C 4: The Board recommends striking the word “service” after employment, and striking “in combination with other day service or residential service” and revising to “concurrently with other waiver services for purposes of job discovery.”** The sentence would read as follows: “For time limited and service authorized periods (not to exceed 24 hours) individual supported employment ~~service~~ may be provided ~~in combination with~~ concurrently with day service or residential services for purposes of job discovery.” This revision helps with clarity.
4. **Subdivision D 4: The Board recommends deleting the second paragraph in this subdivision.** It isduplicative of Subdivision A 3b (“Service Description”) in the same section, and is not related to Provider Requirements.

**12VAC30-122-410 In-Home Support**

1. **Subdivision C 5: The Board recommends proactively adding to the requirement for a back-up plan that an agency can provide back-up support.** While not specifically stated in the regulation, families and individuals have historically been advised by case managers that the back-up plan must be a family member. Since an agency is providing the in-home service, it makes sense that they could also provide the back-up support. Some individuals do not have family members who can provide this service. This should also be clarified in the provider manual.

**12VAC30-122-420 Independent Living**

1. **Subsection A: The Board recommends revision of the second sentence as follows: “**An individual receiving this service ~~typically~~ lives alone or is preparing to live alone.” Since this service is designed to provide skill-building necessary to securing and residing in an independent living situation, it should be available to those planning to transition to more independent living, not just those already living independently.
2. **Subsection A: The Board recommends revision to the final sentence under the service description as follows: “**Independent Living support service shall be covered in the BI and FIS waiver.” There are many individuals in the FIS waiver who wish to live independently, particularly transition age youth who could benefit from this service. It should not be limited to those already in an independent living setting.

**12VAC30-122-430 Individual and family/caregiver training services**

1. **Subdivision 1, The Board recommends striking “the FIS waiver” and adding “in all of the DD waivers.”** Individuals and families receiving services through the BI or CL waiver could benefit from this service. There is no logical reason to only include it in the FIS waiver.
2. **Subdivision C 1: The Board recommends striking this Subdivision, which states that this service is only available in the FIS waiver.**

**12VAC30-440 Nonmedical transportation**

1. **This section is reserved; however nonmedical transportation is now an available service and the Board recommends that the regulations address this service.**

**12VAC30-122-450 Peer support services**

1. **This section is reserved; however peer supports is a service currently in effect (although not being provided) and the Board recommends addressing it in the regulations.**

**12VAC 122-460 Personal assistance services**

1. **Subdivision A 3: the Board recommends adding the following sentence at the end of this subdivision: “Personal assistance can be provided simultaneously with supported employment services and can be billed concurrently.”** The provision currently states that an additional component of personal assistance services is to aid and supports to individuals in the work place, with the final sentence stating, “Work related personal assistance service shall not duplicate supported employment service.” The addition of the suggested sentence at the end of this section clarifies that both can be provided at the same time and that they are distinctly different services.
2. **Subdivision A 4: The Board recommends modifying as follows**: “Personal assistance shall be covered ~~in the FIS and CL waiver~~ in all DD Waivers.” As noted previously, it is unclear why this service is not available in the Building Independence (BI) waiver. Individuals in this waiver are more likely individuals with physical developmental disabilities who may require personal assistance services in order to live independently in their homes. Personal assistance services can be critical to this population.
3. **Subdivisions C 7a & C 7b: The Board recommends striking the term “companion” and replacing it with “personal assistance.”** This is a typographical error as this section covers personal assistance services.
4. **Subdivision C 10: The Board recommends that DMAS closely review all available data regarding the authorization and utilization of personal care since the requirement to provide these solely through EPSDT was put into place. The results of any study/review should be made public.** While it appears that a solution may be at hand and the situation resolved shortly, the Board is concerned with the prohibition of personal assistance services to individuals under the age of 21 who are eligible for such services under the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). There are continuing reports of parents being denied personal care services for their children despite significant needs. EPSDT provides medically necessary services and decisions are made based on medical necessity. Not all personal care services are necessarily medically necessary. The expectation that parents provide these services does not account for parents who work outside the household and need this essential support in order to keep their child at home. This is an issue under the CCC Plus waiver as well, where there are significant numbers of families complaining that personal care (and nursing) services are being denied or reduced.

**12VAC 122-480 Private duty nursing**

1. **Subdivision C 3: The Board recommends DMAS undertake an intensive review of all available data regarding the authorization and utilization of private duty nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served.** **The results of any study/review should be made public.** While it appears as though there may be a resolution to this issue shortly, the Board is concerned about significant numbers of families complaining about reductions in nursing hours for their children who now have to access this service under EPSDT. The Board does not have specific information that would denote whether these complaints relate to skilled or private duty nursing or both. Families who receive significantly reduced hours of this critical service can end up in the position where they would have to choose institutional over home- and community-based care. This is inconsistent with the requirement of the Commonwealth’s Settlement Agreement with the Department of Justice and incongruent with the stated desire to improve care and keep children at home with their families.

**12VAC 122-500 Service facilitation service**

1. **The Board recommends re-examining the role of the consumer-directed services facilitator to eliminate unnecessary duplication of functions and more clearly delineate the roles of services facilitators, support coordinators, and CCC Plus care coordinators.** Service facilitators, support coordinators, and CCC Plus care coordinators are all responsible for monitoring waiver services. This can result in duplication of effort, diffusion of responsibility, confusion, and reduced individual ownership of responsibility. It can also unduly burden individuals who must accommodate multiple home visits and assessments. When various parties have overlapping roles, DMAS should either distinguish how each party’s contribution to the overall role differs from the others’ contributions or, if the contributions do not differ, consolidate the role under fewer parties. If the majority of the service facilitator’s roles are also shared by other parties, which appears to be the case, DMAS should also consider transferring the remaining roles (such as training employers of record and reviewing timesheets) to the other parties and eliminating the service facilitator position. The cost of this service should be analyzed in relation to the benefit achieved for the funding agency and the consumer.
2. **Subdivisions B 3, B 4, and B 8: The Board recommends changes that would ensure that these subdivisions, which address face-to-face meetings between the individual and the service facilitator, be consistent with one another.** Subdivision B 3 states that face-to-face meetings shall occur between the service facilitator and the individual at least every six months. However, Subdivisions B 4 and B 8 refer to quarterly routine visits. The Board recommends every six months per Subdivision B 3, unless the individual requires or requests more frequent contact.
3. **Subdivision 500 C 1: The Board recommends modifying the last sentence of this subdivision to state, “The support coordinator shall document in the individual’s record that the individual can serve as the EOR or if there is a need or desire for another person to serve as the EOR on behalf of the individual.”** Individuals who are capable of, but unwilling to, direct their own care should be allowed to designate an EOR if desired.

**12VAC30-122-520 Skilled nursing service**

1. **Subdivision B 4: The Board recommends DMAS undertake an intensive review of all available data regarding the authorization and utilization of skilled nursing since the requirement to provide this service solely through EPSDT was put into place in order to determine, on a systemic level, whether families are being adequately served.** **The results of any study/review should be made public.** While it appears as though there may be a resolution to this issue shortly, the Board is concerned about significant numbers of families complaining about reductions in nursing hours for their children who now have to access this serve under EPSDT. The Board does not have specific information that would denote whether these complaints relate to skilled or private duty nursing or both. Families who receive significantly reduced hours of this critical service can end up in the position where they would have to choose institutional over home and-community-based care. This is inconsistent with the requirement of the Commonwealth’s Settlement Agreement with the Department of Justice and incongruent with the stated desire to improve care and keep children at home with their families.

**12VAC30-122-540 Supported Living Residential**

1. **Subsection A: Consistent with comment #19 in 122-20, Definitions, the Board recommends deleting “an apartment setting”, and changing to a service “taking place in the individual’s own home.”** Not all supported living residential settings are apartments.

**12VAC30-122-570 Workplace Assistance**

1. **Subdivision B 4: The Board recommends adding an “e” at the end of the lettered list which adds phone, media, and in-person contacts with a job coach as allowable/billable activities.** There may be instances in which the workplace assistant may need to consult with the individual’s job coach in order to best meet the individual’s needs and to ensure consistency of strategies designed to support the individual to be successful in the workplace.

**The Board supports the following recommendations to 12VAC30-122-60 put forth by advocate and provider members of the DD Waiver Advisory Committee, of which the Board is a member.**

1. **Implement a Special Group Category Consideration.** SSI/SSDI waiver recipients increasingly have retired, disabled or deceased parents and the waiver recipient’s income increases because their parent’s FICA account is opened and a portion of this account is received by the waiver recipient. This amount (now SSDI) often puts the waiver recipient over the 300% gross income limit. The causes the individual to stop working. These individuals should be put in a “protected category” which will disregard the amount of the new income (SSDI) that will cause them to become ineligible for waiver services. This protection is considered when looking at continued Medicaid eligibility.
2. **Recommend Subsidies and Special Conditions as deduction for wages earned (per SSA definitions**). If the individual is not fully earning his or her wages because the work is performed under special conditions (e.g. close and continuous supervision, on the job coaching, etc.), then the Commonwealth should deduct that part of his or her wages that are not “earned” by the individual from his/her average gross wages. This is true whether or not the employer or someone else provides the special on-the-job conditions. Most work supports that an individual receives in order to earn income is provided under LTC (i.e. transportation, personal attendant services, job coaching, etc.). However, under current Medicaid LTC regulations, if the individual earns over 300% of federal benefit rate (FBR), they are penalized. Many individuals do not have the out-of-pocket expenses that are needed to bring down countable earned income due to the LTC supports that they are receiving at no cost to them. However, they would not be earning at the level that they are earning without the waiver provided supports. Subsidies and Special Conditions would give value to the supports that are provided to the individual that enables them to work and earn income.
3. **Recommend Spend-down for all Long-Term Care waiver categories**. This language is already in the CCC+ waiver. This language should be moved to all categories.

The Board looks forwarded to continuing to work with DMAS, DBHDS, and other stakeholders as redesign implementation continues. Thank you for the opportunity to provide input.